Testimony of

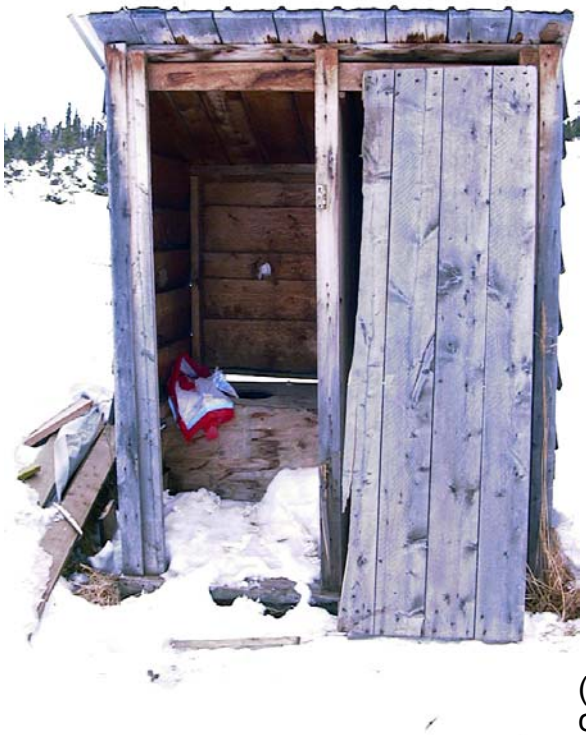
STEVEN WEAVER

Director, Division of Environmental Health and Engineering
Alaska Native Tribal Health Consortium

Before a Joint Hearing of
The Senate Committee on Indian Affairs
and
The House Resources Committee

Regarding the Health Facilities and Sanitation Provisions of S. 556 and H.R. 2440, Bills to Reauthorize the Indian Health Care Improvement Act

July 16, 2003



(LEFT) OUTHOUSE:
The only lavatory available to the health clinic in Lime Village, Alaska is a dilapidated outhouse.

(BELOW) HEALTH CLINIC: The newly constructed health clinic in Kiana, Alaska. This facility contains a completed piped water and sewer system.

(LEFT) HONEY BUCKETS:
For decades, honey buckets have defined rural Alaskan sanitation standards. While practical, their use and disposal create unsanitary living conditions that expose people to disease.

(RIGHT) PIPED WATER AND SEWER SYSTEMS:
Permafrost (permanently frozen soil) prevents water and sewer utilities from being buried in many northern Alaskan communities.

Piped water and sewer systems allow for no exposure to human waste and provide a dependable, year-round water source for community members.

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Chairman Campbell, Chairman Pombo, and members of the Committees, thank you for the opportunity to testify regarding S. 556 and H.R. 2440, the Senate and House bills that would reauthorize the Indian Health Care Improvement Act. I appear today on behalf of the Alaska Native Tribal Health Consortium (ANTHC), where I serve as Director of the Division of Environmental Health and Engineering (DEHE).

I am accompanied by Chief Andrew Jimmie of the Minto Traditional Council, who appears this morning in his capacity as Vice-Chair of the Alaska Native Health Board. Chief Jimmie also serves as President of the Tanana Chiefs Conference Regional Health Board, and recently received the prestigious Alaska Federation of Natives Health Award.

At the invitation of the Committees, I would like to discuss ANTHC's statewide sanitation and health facilities construction program, carried out in conjunction with the tribal health providers throughout the State, , and the vital role of this program in disease prevention and health promotion. Through sharing our experiences in Alaska, I hope to clearly portray the challenges presented by unmet sanitation and health facility needs in American Indian and Alaska Native communities nationwide.

Table 1 presents the Alaska component of the national AI/AN unmet sanitation needs as reported by the Indian Health Service (IHS) Sanitation Deficiency System for fiscal year 2003.

Table 1.
National and Alaska Unmet Sanitation Needs for FY 2003

Category	Unmet Need
National Total	$1,593,529,976
Alaska Component	$637,262,519

Table 2 further illustrates the extent of the unmet needs in Indian Country by presenting the percentage of various categories of homes in the United States that do not have potable water in the home. The national AI/AN rate is more than 7 times the "All U.S." rate for homes that do not have potable water. The 25% of Navajo and 38% of Alaska Native homes without potable water are even higher.

Table 2.
Percentage of Various Categories of Homes without Potable Water

Categories of Home	Percentage of Homes without Potable Water
All U.S. Homes	1%
All American Indian/Alaska Native Homes (AI/AN)	7.5%
Navajo Reservation Homes	25%
Alaska Native Homes	38%

Alaska Native's have the highest percentage of homes without potable water in the home and experience the greatest discrepancy between all U.S. homes of which only 1% do not have potable water in the home.

The sanitation facilities construction program is a cornerstone in the foundation of today's Indian Health Network. Much has been accomplished, and much remains to be done

At the current funding level the Indian health system unmet need is increasing annually at a rate $50 million faster than construction. And just as disturbingly, the "All AI/AN Homes" percentage of homes without potable water presented in Table 2 has remained at 7.5% for the last six years.

Third World Sanitation in 21st Century Alaska

Rural Alaska has many unique conditions that magnify the challenges faced throughout Indian communities in the provision of a safe water supply and sanitary waste disposal. Vast distances, isolated and remote locations accessible only by air or water, and extreme temperatures are just a few of the factors impacting the provision of sanitation facilities to Alaska Natives. Even today over thirty percent of Alaska Native homes still lack piped water and sewer facilities. And in far too many Alaska Native communities, residents still have no choice but to shoulder the daily responsibility of hand-carrying the family drinking water supply into their homes, as well as hand-carrying the family's wastewater and human waste back out again.

In Alaska the Sanitation Facilities Construction program primary focus is on protecting the public health. But given the large unmet need, other goals have been integrated into the program to maximize its benefits for Alaska Natives, including:

- Promoting healthy lifestyles;
- Building basic community infrastructure;
- Providing local jobs and job training; and
- Promoting economic growth

Many challenges lay ahead. Of great concern to Alaska is the impact of changes to federal environmental regulations. Increasingly complex water quality and treatment regulations are causing huge increases in capital construction and system operating costs. Between 1993 and 2006 at least 13 federal drinking water related rules have been implemented or are scheduled for implementation. Examples include:

- The Lead and Copper Rule
- The Interim Enhanced Surface Water Rule
- The Arsenic Rule
- The Disinfection/Disinfection By-Products Rule
- The Filter Backwash Recycling Rule

Each regulation has an associated capital and operating cost increase. Some have even required that entire water treatment facilities be replaced to meet new operating criteria. While Alaska's goal is clean water that meets national standards, we need a common sense "first things first" approach as we seek to put basic infrastructure in place. On-the-ground realities of situations such as ours must be factored into the implementation of these new regulations to avoid doing unwarranted harm to the compelling national policy goals underlying the IHS SDS system.

Alaska Native Health Facilities Overview

The Native health network in Alaska is comprised of the Alaska Native Medical Center, 6 Regional Hospitals, and some 180 sub-regional and community health aide clinics. The current documented unmet need for Alaska Native health facilities exceeds $630 million. The oldest hospital in the network has been in operation in Nome since 1948. It has been on an IHS priority list for replacement along with the regional hospital in Barrow for 15 years. The St. Paul Clinic has been in operation since 1926 and is now in the process of being replaced by the IHS.

Given the remote nature of our communities, the village clinics form the foundation of our health care system. A 2001 clinic facilities status survey found that only 17% of reporting facilities were judged as adequate. Many lack even the basics of running water. Imagine receiving medical care in a facility where medical professionals cannot practice the fundamentals of good hygiene. The Yukon- Kuskokwim Health Corporation reported in 2003 that only 51% of their 47 clinics had piped water and sewer services. They also indicated that 34% rely on honey buckets and outhouses for waste disposal. The Lime Village clinic outhouse pictured above is not unique.

Key Sanitation and Facilities Provisions of H.R. 2440, Compared to S. 556

It has been over 25 years since the original enactment of the Indian Health Care Improvement Act. Now, this latest effort at reauthorization, in which these Committees have cooperatively taken a leadership role, truly proves how much has been accomplished. Under the leadership of the National Steering Committee, including tribal leaders from every Area and representatives of the IHS and national Indian organizations, the 1999 National Steering Committee (NSC) draft, largely embodied in S. 556, has been improved even further as reflected in H.R. 2440. Although there was significant consultation prior to completion of the 1999 NSC Draft in the three years that have passed, tribal leaders have had an opportunity to reflect more on the choices and to consider the initial comments of the Department of Health and Human Service to S. 212 (the predecessor to S. 556). The product of this additional work is found in H.R. 2440.

Passage of the Indian Health Care Improvement Act reauthorization is urgently needed in order to achieve the efficiencies and to make available the opportunities provided for in the two bills. The reauthorization bills fundamentally enhance the ability of the Indian Health Service and Tribes to deliver critically needed services, as well as clarify operational authorities and requirements in the management of facility programs. Language improvements in Title III of H.R. 2440 build on the original work of the NSC and the Senate.

I would like to highlight a few of the important provisions of Title III and comment on some of the differences between the Senate and House bills.

C better meet the needs of the Secretary by more clearly establishing the requirements and purpose of accreditation of health care facilities while maintaining the flexibility to the facility manager as to selection of the accrediting body. In response to concerns expressed by the Administration, H.R. 2440 specifies that the construction standards be ones that will satisfy the requirements of the Medicare, Medicaid and SCHIP programs under the Social Security Act.

C provides for the establishment of Service Area priorities in addition to more comprehensive National priorities. *See* H.R. 2440 section 301(c)(2)(B)(I). This promotes and provides Tribes more opportunity to seek non-federal funding for high priority health facility projects within Service Areas. It also expands the list of prioritized facilities to include all staff quarters' developments and hostels to provide a more accurate report.

H.R. 2440 differs in one other important respect from S. 556. S. 556 requires that "life expectancy" must be treated as a factor in giving additional priority for facilities. S. 556 section 301(c)(1)(B). H.R. 2440 does not include this limiting priority. H.R. 2440 section 301(c)(1)(A). Instead, like the 1999 NSC Draft, the factors for determining priorities are not predetermined and will be developed through negotiated rulemaking with Indian Tribes and tribal organizations. I urge the Committee to consider adopting the a similar approach. The range of factors that may be relevant is significant and each possible factor deserves the close technical examination that rulemaking is well-suited to accomplish.

C The Departent of Health and Human Services criticized this provision of S. 212 (also found in S. 556) and the 1999 NSC Draft, both of which require an annual report by the Secretary listing all facility needs of the IHS, Tribes, tribal organizations, and urban Indian organizations, including the need for renovation and expansion. The Secretary expressed concern about the complexity and cost of preparing such a report. The NSC responded by asking that H.R. 2440 require that the initial report be developed by the General Accounting Office and that in subsequent years updates be done by the Comptroller General and Secretary in consultation with Indian Tribes, tribal organizations and urban Indian organizations. This is a fair compromise that will still achieve the important objective of providing to the Congress a complete picture of the unmet need for new facilities and for improvements and expansion.

C eliminates the prohibition of the use of P.L. 86-121 sanitation facilities construction funds for HUD funded homes. In its place it makes HUD funded homes eligible, but at a lower priority than other existing and new Indian homes. *See* H.R. 2440 section 302(c)(3)(A) and (B). Once again, this seems a fair compromise position between current law and S. 556, which prohibit the use of funds for HUD funded homes and the advocacy position of the National American Indian Housing Counsel (NAIHC), which seeks equal status for HUD funded homes with all other homes.

Currently the Indian Health Service (IHS) maintains a central database that tracks and reports unmet sanitation needs in Indian country. This program is currently authorized to provide sanitation facilities for other than HUD funded Indian homes only. At its current funding levels, some 900 eligible Indian owned homes remain unserved each year. As HUD funded homes are not eligible for assistance under this program, this need is not tracked, making current reports to Congress incomplete. By authorizing the use of P.L. 86-121 dollars for HUD funded Indian owned homes at a lower priority than those currently authorized, a centralized national database of unmet sanitation need can be readily operated by the IHS with existing resources. Existing eligible housing remains the top priority for service, and tribally designated housing authorities are encouraged to work cooperatively in the orderly planning and construction of basic community infrastructure.

C defines the term "sanitation facilities" and then uses the term in place of a descriptive phrase used throughout the S.556. This adjustment makes the law much easier to read and understand.

C establishes a prevailing wage rate process consistent with NAHSDA, enabling Tribes to administer their programs more efficiently. Nationally Indian housing programs are funded at a rate some ten times greater than that of sanitation facilities construction. Tribal construction process and practice is typically centered around and based on the requirements of the NAHSDA program due to its size. H.R. 2440 would enable Tribes to realize economies of scale not otherwise possible in the administration of its construction projects.

In Alaska, a tribally managed prevailing wage rate process would be more responsive to local needs and based on information collected in tribal communities. The last applicable wage survey was conducted in 1996, published in 1999, and did not include interior and northern Alaska where most of our Tribes are located.

C The new language in both bills regarding treatment of leases by the Secretary of Tribal facilities as operating leases for the purposes of scoring under the Budget Enforcement Act provides an important new opportunity for Tribes to participate in funding the facility needs of their health programs.

- provides a similar opportunity to increase the options for addressing the devastating underfunding of Indian health facilities.

- establishes a demonstration project process under which eligible Tribes may expend non-federal funding to construct a new facility and the IHS provides the funding necessary to staff and operate that facility. By broadening the window of eligibility for Tribes to participate beyond the actual period of facility construction, the reauthorization bill allows Tribes the opportunity to make sound financial commitments without increasing the cost of IHS participation, since a commitment by the IHS to participate prior to the irrevocable commitment of substantial funding by a Tribe is now possible.

ANTHC Organizational Background

ANTHC was formed in December 1997 to assume all non-residual IHS statewide services. It is the first tribal Area Office in the IHS system. ANTHC's board is representative of all Tribes in Alaska. It is one of the twenty co-signers of the Alaska Tribal Health Compact, the largest self-governance compact with the IHS.

ANTHC's mission is to provide the highest quality health services for all Alaska Natives.

Based in Anchorage, ANTHC offers a wide-range a range of services across Alaska. ANTHC co-manages the Alaska Native Medical Center, the tertiary care hospital for the Alaska Native health system. In support of its own programs and those of tribal health programs throughout Alaska, ANTHC provides centralized purchasing of medical supplies and pharmaceuticals, provision of specialty medical care services, centralized professional recruiting and credentials verifications, technology development, health research, and the AFHCAN project.

Working in with Native communities and organizations on the local, state, and federal levels, DEHE plans, designs, and constructs sanitation facilities, bringing safe water and wastewater disposal improvements to thousands of Native-owned homes. In 2002, 3,660 Native homes were served. This year, DEHE provided sanitation facility improvements in 92 Alaska communities.

In 2002, DEHE administered 36 maintenance and improvement projects for health care facilities managed by 11 tribal health organizations. In addition, through a partnership with the Denali Commission, DEHE manages a program that plans, designs, builds, and renovates health clinics. This year the Division completed clinic projects in 12 communities and started projects in 44 others.

In support of these sanitation and facility construction programs, ANTHC DEHE offers other tribal health programs access to a design and engineering group, construction project management, and the Alaska Utility Supply Center. The Center offers village operators a single source for material and equipment for utility systems, saving operation downtime and providing bulk purchasing economies. The supply center currently has 115 active community accounts.

Conclusion

In conclusion, I would again thank Chairman Campbell, Chairman Pombo, and the respective Committee members for this opportunity to share an Alaskan perspective from "the trenches." On behalf of myself, my Division, and the Alaska Native Tribal Health Consortium, I look forward to continuing to work in partnership with the Congress and the Indian Health Service to build healthy and safe American Indian and Alaska Native homes and communities. Thank you, I would be happy to answer any question you may have.

ANTHC DEHE projects offer value in fundamental ways:
they provide basic sanitation and health services for Alaska Natives,
advance community economic development, and
help improve the present and strengthen the future of Alaska Native people.